



EUROPEAN UNION

**Parallel workshop 2 –
Integrate palliative care across
the whole cancer continuum:
boost social innovation,
enhance cross-sectoral
collaboration, and ensure
dying with dignity.**



**5 years Cancer Mission:
Stronger Through Connection**

BRUSSELS
29 SEPTEMBER – 01 OCTOBER

Parallel workshop 2 - Integrate palliative care across the whole cancer continuum: boost social innovation, enhance cross-sectoral collaboration, and ensure dying with dignity.



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EUROPEAN UNION



EU Navigate

Integrating palliative care across the cancer continuum: EU NAVIGATE

Prof. dr. Lieve Van den Block
VUB-UGhent End-of-Life Care
Research Group, Belgium

September, 30, 2026



**5 years Cancer Mission:
Stronger Through Connection**

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29 SEPTEMBER – 01 OCTOBER



5 years Cancer Mission: Stronger Through Connection



The human crisis in cancer: a *Lancet Oncology* Commission



Gary Rodin, Amalya Feldman, Dario Trapani, Mac Skelton, Karla Unger-Saldaña, Beverley Essue, Rille Pihlak, Catherine Walshe, William E Rosa, Matthew P Banegas, Miguel Zambrano-Lucio, Rawaz Salah Daood, Ajay Aggarwal, Omar Dewachi, Gilla K Shapiro, Murallitharan Munisamy, Harenthri Devy Alagir Rajah, Shrikant Atreya, Vijay Shree Dhyani, Yek-Ching Kong, Mebin Mathew, Carol Y Ochoa-Dominguez, Arathi Prahallada Rao, Seema Rajesh Rao, Srinagesh Simha, Nancy Preston, Wendy Wing Tak Lam, Hanae Davis, Camilla Zimmermann, Eve Namisango, Christian Ntizmira, Elizabeth Smyth, Madeline Li, Naveen Salins, Nirmala Bhoo-Pathy, Richard Sullivan

Amid unprecedented scientific progress in oncology, a growing body of evidence reveals a parallel and profound crisis in the human experience of cancer care. Despite overall survival outcomes improving, the systems designed to deliver care increasingly fall short in addressing the emotional, relational, and existential dimensions of cancer. Although examples of compassionate and attentive care can be found in every setting, patients and families across global contexts continue to report being unheard, unsupported, and, at times, actively harmed by care structures that

Lancet Oncol 2025; 26: e628-70

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[https://doi.org/10.1016/](https://doi.org/10.1016/S1470-2045(25)00530-3)

[S1470-2045\(25\)00530-3](https://doi.org/10.1016/S1470-2045(25)00530-3)

“Despite overall survival outcomes improving, the **systems** designed to deliver care increasingly **fall short in addressing the emotional, relational, and existential** dimensions of cancer.... This crisis is shaped by what is present and what is absent: the presence of **fragmented, costly, and impersonal systems and the absence of human connection, psychological safety, and relational care**... Addressing this crisis will require more than good intentions; it will demand **confronting the structural incentives and ideologies** that have devalued the relational foundations of cancer care.” (Rodin et al, 2025)



“ Rehumanising cancer care is necessary and possible. There is strong and growing evidence for a set of approaches that improve patient experience, reduce suffering, and support health-system resilience. These include patient navigation, early integration of palliative care, financial protection mechanisms, and culturally relevant mental health support.”
(Rodin et al, 2025)

5 years Cancer Mission: Stronger Through Connection



HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF 44

What are patient navigators and how can they improve integration of care?

Hannah Budde
Gemma A Williams
Giada Scarpetti
Marieke Kroezen
Claudia B Maier

Current Oncology Reports (2024) 26:504–537
<https://doi.org/10.1007/s11912-024-01514-9>

REVIEW

Patient Navigation in Cancer Treatment: A Systematic Review

Matthew Chen¹  · Victoria S. Wu¹ · Derek Falk¹ · Chesley Cheatham² · Jennifer Cullen¹ · Richard Hoehn²

Accepted: 4 March 2024 / Published online: 6 April 2024
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European Geriatric Medicine
<https://doi.org/10.1007/s41999-026-01609-5>

REVIEW



Scoping review on navigation interventions for older adults with cancer in Europe and beyond

Agata Stodolska¹  · Grzegorz Wójcik² · Carla Reigada³ · Kelly Ashford⁴ · Rose Miranda^{5,6} · Lieve Van den Block^{5,6} · Emilia Malmur¹ · Natalia Drapała¹ · Katarzyna Szczecińska^{1,7} 

Received: 26 May 2026 / Revised: 26 August 2026 / Accepted: 3 September 2026
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*Chan et al 2022 Oppong et al 2024, Chen et al,
2024, Rodin et al 2026, Stodolska et al 2026*

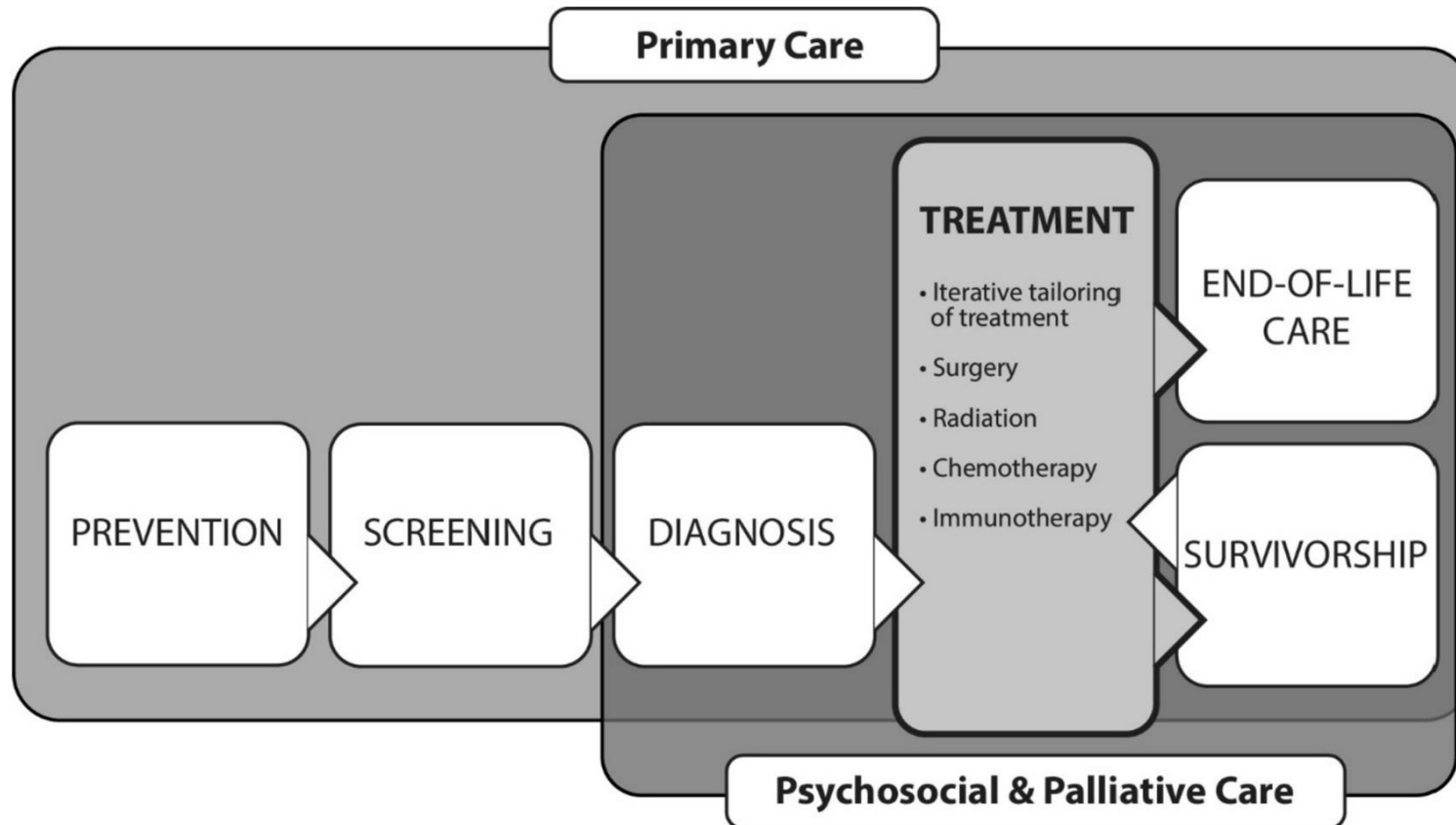


What is navigation?

- Aimed at supporting people to find their way through health and social care systems, help them overcome barriers to accessing services, and improve continuity of care (often targeted at people in disadvantaged positions)
- Use “navigators” i.e. qualified health professionals (nurses, social workers) or trained lay persons (often recruited from the community that is targeted)
- Variable and flexible tasks such as identifying needs and barriers, psycho-education, linking people to their communities, and to health and social care services (some professional navigators also perform clinical tasks such as care coordination)
- Different words: care navigators, patient navigators, lay navigators, community health workers, or other



Cancer navigation



- mostly US studies
- often targeting parts of the trajectory
- less focus on palliative care
- limited attention to multidimensional needs of older people with cancer including practical, financial, social, existential.

Implementation and evaluation of a navigation intervention for older people with cancer and their family carers: an international pragmatic RCT

Sept 2022 – Sept 2027



Adapting, implementing and evaluating a navigation intervention for older people with cancer and their family caregivers in six countries in Europe: the Horizon Europe-funded EU NAVIGATE project

Rose Miranda¹, Tinne Smets, Lara Pivodic, Kenneth Chambaere¹, Barbara Pesut¹, Wendy Duggleby, Bregje D. Onwuteaka-Philipsen¹, Barbara Gomes¹, Peter May¹, Katarzyna Szczerbińska, Andrew N. Davies, Davide Ferraris, H. Roeline Pasman, Maja Furlan de Brito¹, Ilona Barańska¹, Laura Gangeri, on behalf of EU NAVIGATE* and Lieve Van den Block

Palliative Care & Social Practice

2024, Vol. 18: 1–17

DOI: 10.1177/

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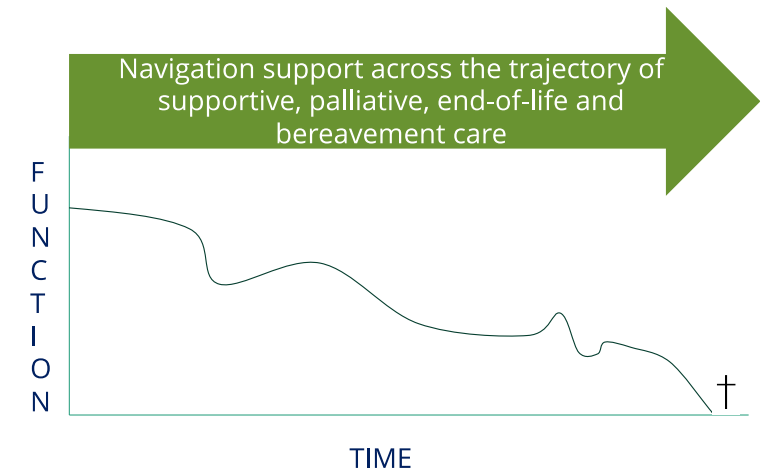


Unique to EU NAVIGATE

- Older people with cancer and 'declining health' (using Clinical Frailty Scale) and their close family carers
- Focus on the whole post-diagnostic trajectory
- Providing navigation and companionship
- Support in the community: improving access to health and social care services, but also to community and voluntary sector
 - Building cross-sectoral alliances
- Start from >15 years experience in Canada as a social innovation



Nav-CARE
Making Connections, Making a Difference



Methods and Methodology

Systematic adaptation of public health palliative care interventions across settings using ADAPT guidance: Methodological learnings from the EU NAVIGATE project

Fien Van Campe^{1,2,3} , Kenneth Chambaere^{1,3} , Lara Pivodic^{1,2} ,
Joni Gilissen^{1,2,3,4}, Barb Pesut⁵, Wendy Duggleby⁶ , Tinne Smets^{1,2} ,
Katarzyna Szczepińska⁷ , Maja Furlan de Brito^{8,9} , Andrew Davies¹⁰,
Davide Ferraris¹¹, Annicka van der Plas¹², Bianca Scacciati¹³ ,
On Behalf of EU NAVIGATE* and Lieve Van den Block^{1,2}

PALLIATIVE
MEDICINE

Palliative Medicine
2025, Vol. 39(4) 460–472
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DOI: 10.1177/02692163251320507
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Sage



Navigators



- Trained and continuously mentored
- Volunteers (and social workers)
- Matched with clients



Italian navigator with client

WHAT IS MOST IMPORTANT TO YOU TODAY?



Fast-track RCT with process and cost evaluation

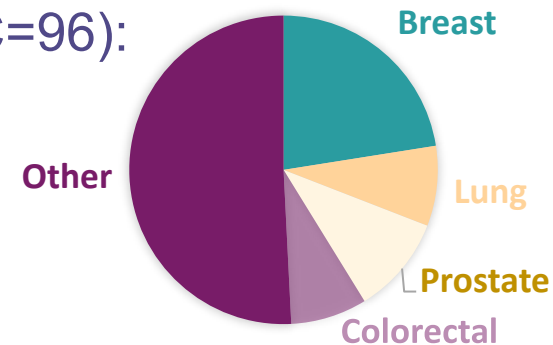
Primary outcomes: quality of life and social support after 6 months

327 clients from 6 countries randomized:

- 177 immediate intervention and 150 control group with intervention after 6 months
- 31,5% drop-out due to deterioration, death, or other reasons

214 clients with completed primary outcome data (I=118; C=96):

- age between 70y and 92y; 56% female
- 1/3 lived alone; 1/2 has close family caregiver



179 navigators: wide age range (19+ to 70+) (most between 50-70y)

Average visit length is 80 min



Preliminary
results



Practical

- › Arranged (cheap) house help
- › Helped buy a tricycle
- › Helped arrange caregiving reimbursements
- › Helped to use WhatsApp

Social

- › Someone to talk to, just being there is enough
- › Go out for coffee
- › Helped me do some activities in local community centre which client could not do alone anymore

Emotional

- › Visited grave of late husband together
- › Talking about health issues, which client found difficult to do with family
- › Visited town where patient grew up

Preliminary
results

THANK YOU

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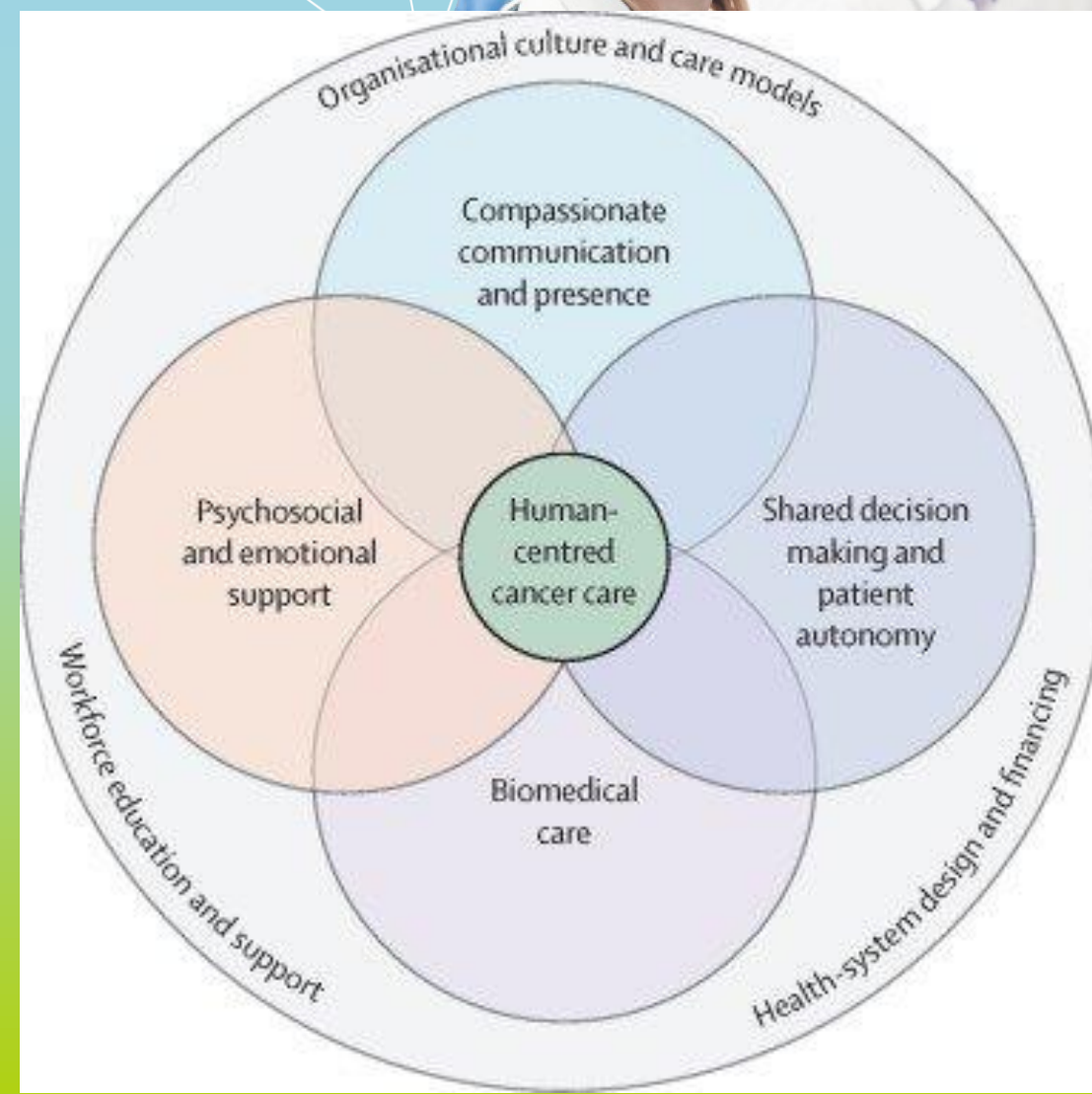
Funded by
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To enable relational, dignified, and human-centred cancer care, not only a biomedical lens is needed (focusing on cure, control, technological progress, and market economy), but also compassionate communication, shared decision-making, and psychosocial and emotional support. These should be embedded within broader systems of organisational culture, workforce education, and health system design; each of which must align.



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EUROPEAN UNION



Pal-Cycles

Integrating palliative care across the cancer continuum:

The evolution of transitional palliative care



Prof. Dr. Jeroen Hasselaar
Radboudumc Nijmegen
The Netherlands

September, 30, 2026

Radboudumc

5 years Cancer Mission:
Stronger Through Connection

BRUSSELS

29 SEPTEMBER – 01 OCTOBER

Cancer is the leading driver of palliative care need in Europe

Palliative care needs of people who die each year with serious health-related suffering (SHS) associated with cancer

Selected countries of the WHO European Region (thousands)

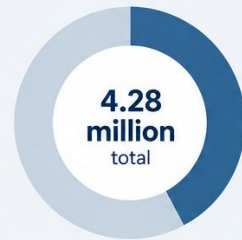


Source: EAPC Atlas of Palliative Care in the European Region 2025, Table 3.

Estimated number of people who die each year with serious health-related suffering (SHS) associated with cancer (in thousands). Estimates are based on the Lancet Commission SHS database (2015).

1.82 million

people with cancer die each year experiencing serious health-related suffering (SHS) in the WHO European Region



42.5%

of all people with palliative care need in the European Region have cancer



7,119

specialised palliative care services across the European Region

0.96

median services per 100,000 population

Almost one in every two people dying with serious health-related suffering in the European Region has cancer.

The challenge is no longer only demonstrating need. It is ensuring equitable access to palliative care wherever people with cancer live.

Over 4 million people faced SHS in the European region

CONDITION	SHS IN THOUSANDS
Cancer	1,818,424
Cerebrovascular diseases	738,226
Dementia	333,755
Lung disease	311,535
Non-ischemic heart disease	183,778
Other causes	893,560
Total	4,279,278

¹ Source: The Lancet Commission on Global Access to Palliative Care and Pain Relief. Serious health-related suffering database, 2015.



Cancer accounts for approximately 42–43% of the estimated need for palliative care.

Garralda E. et al. *EAPC Atlas of Palliative Care in the European Region 2025*. ATLANTES Global Observatory & European Association for Palliative Care. EAPC Atlas of Palliative Care in the European Region 2025, Table 3, pp. 34–35.



Problem

- Over-medicalisation of dying
- Hospital-centred deaths
- Limited community involvement

Key imbalance

- Too much medical intervention
- Too little community & social support

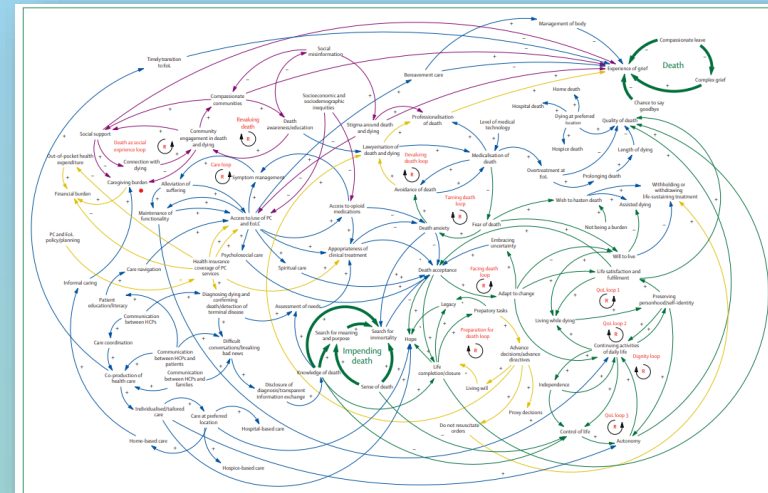


Figure 3: An example of a dynamic map of an end-of-life system
EoL=end of life. HCPs=health-care providers. PC=primary care. QoL=quality of life. R=reinforcing loop. B=balancing loop

What needs to change

- Earlier integration of palliative care
- Stronger community support

Key message

- **Bring death back into life**

[illegible]

Reference: Sallnow L et al. Report of the Lancet Commission on the Value of Death. The Lancet, 2022.



Cancer mission: policy brief palliative care

- Demonstrate the value of Palliative Care
- Integrate across care continuum
- Tackle inequities
- Innovate/implement knowledge
- Empowerment patients/public
- Anticipate future needs



Innovative palliative care for people with cancer:
sustainable solutions for the future

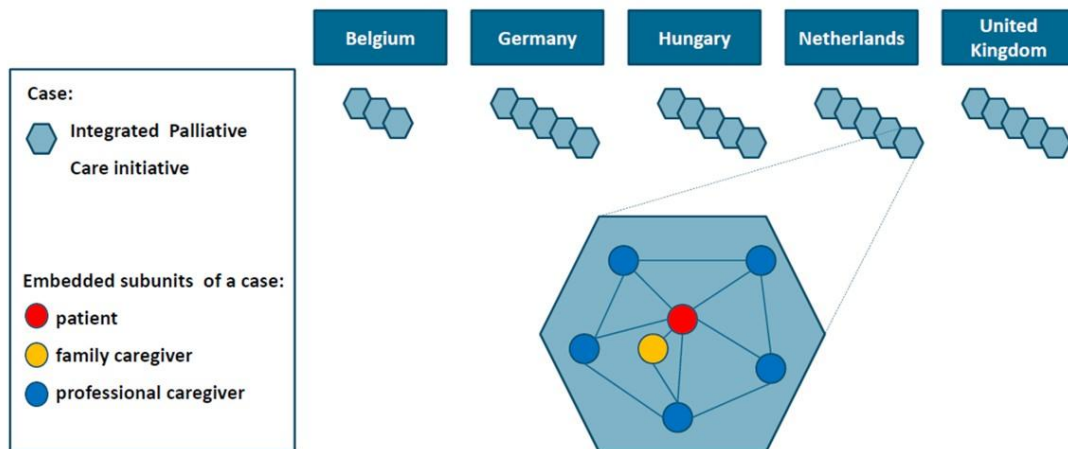


Lessons learned from 2 European projects

Project 1: Integrated and supportive care InSUPC (2013-2016)



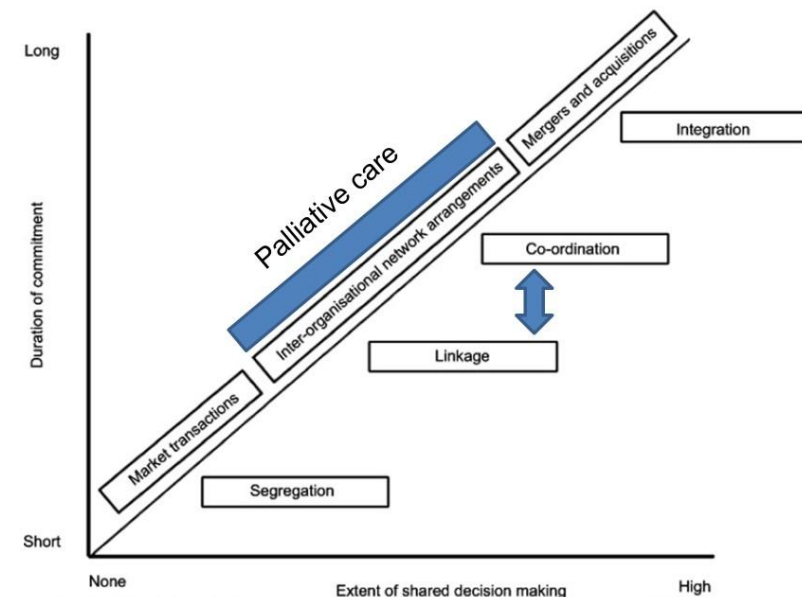
Multiple embedded case study



Including Network Analysis



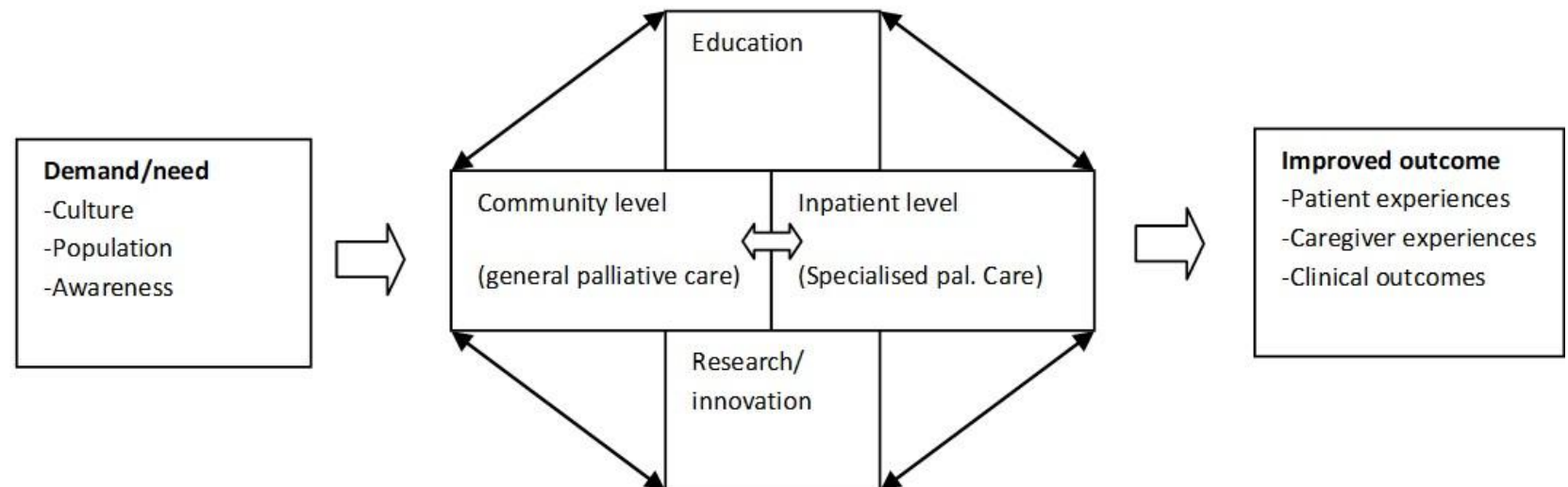
Commitment & decision-making



Valentijn P et al. Understanding integrated care. International Journal of Integrated Care. 2013.



Project 1: Integrated and supportive care InSUPC (2013-2016)





Project 2: PalCycles 2022-2027



Pal-Cycles



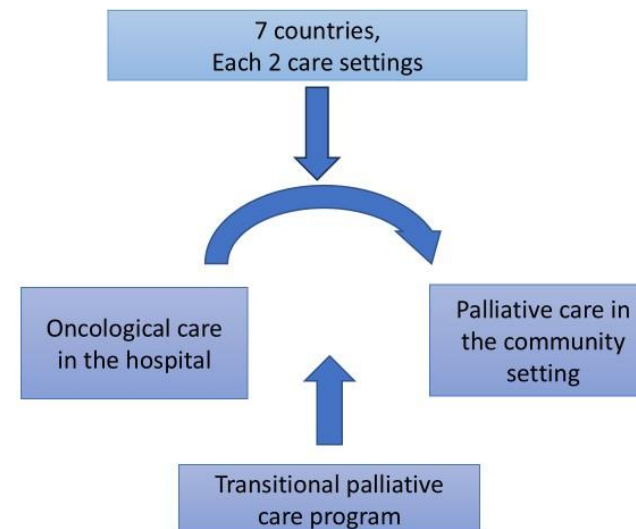
Funded by the
European Union

Project: 101057243 - HORIZON-HLTH-2021-DISEASE-04

Time: 2022-2027

Coordinator: Radboudumc
Prof Dr GJ Hasselaar

Objective: the development, implementation
and evaluation of a transitional palliative care
programme



Radboudumc

Lancaster
University

ukb universitäts
klinikum bonn

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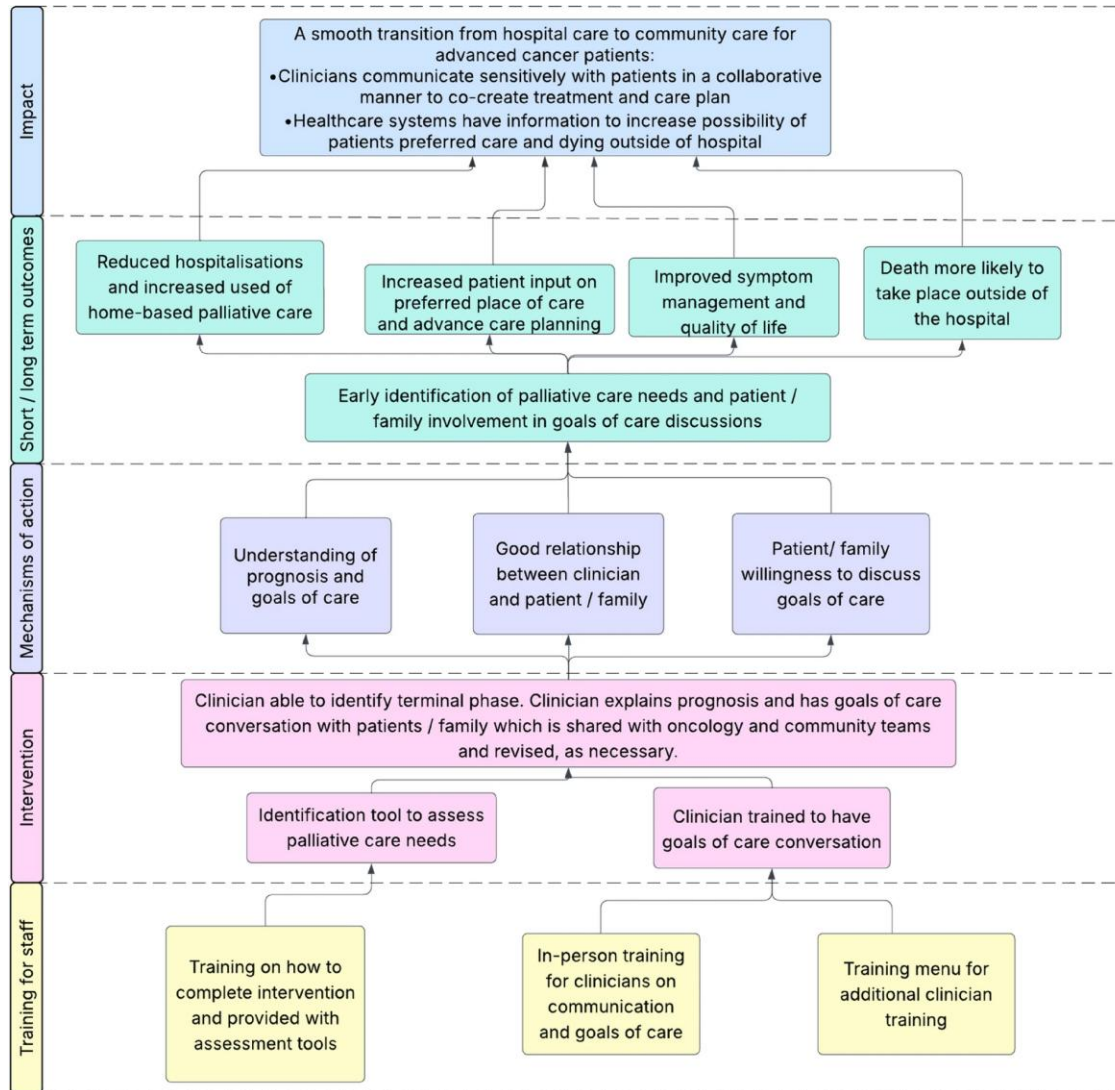
PÉCSI TUDOMÁNYEGYETEM
UNIVERSITY OF PÉCS

HOSPICE Casa
Speranței 30 DE ANI

UJZ UNIVERSITY
OF ZIELONA GÓRA

EAPC
VZW

5 years Cancer Mission: Stronger Through Connection



Hooley R, Payne S et al. BMC Palliat Care. 2026

ORIGINAL INTERVENTION

FIVE COMPONENTS

- 1 IDENTIFICATION**
Identification of a patient with palliative and supportive care needs in collaboration with the oncologist and multi-disciplinary team
- 2 COMMUNICATION**
Compassionate communication with the patient and their family
- 3 COLLABORATION**
Collaborative effort to establish a multidimensional treatment plan and follow-up
- 4 REVIEW**
Periodic review and evaluation of the treatment plan with patients and relatives, led by the oncologist and multi-disciplinary team, depending on patient's place of stay, care needs, and local possibilities
- 5 FINAL PHASE**
Identification of the end of life phase (if required) based on evaluations, with appropriate referral for palliative care and end-of-life communication, e.g. withdrawal of futile treatment, preferred place of death, rituals in the last phase of life



PAL_CYCLES

FIVE COMPONENTS

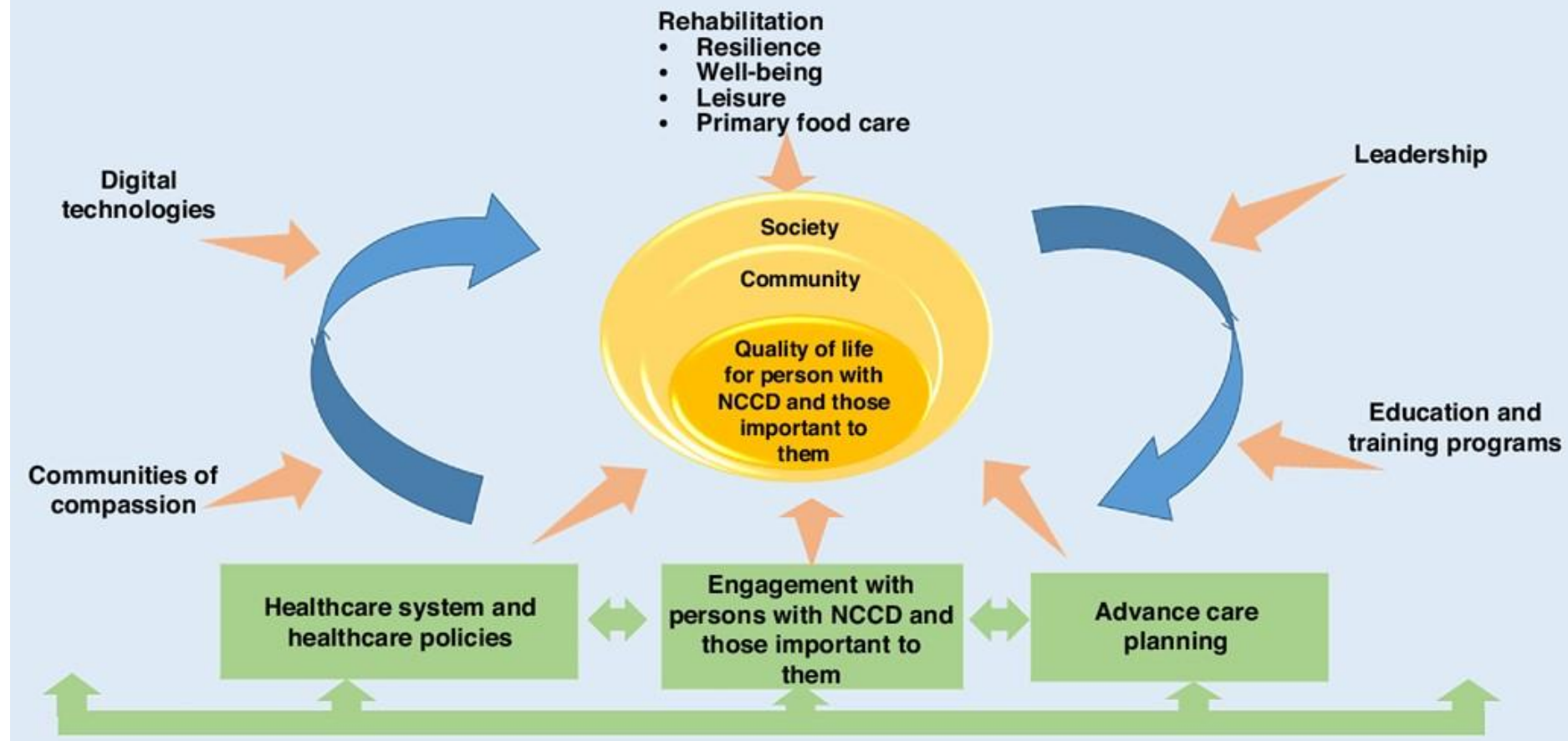
- 1 IDENTIFICATION**
Identification of a patient with palliative and supportive care needs **using the 6-month surprise question** ("Would you be surprised if the patient were to die within 6 months?")
- 2 COMMUNICATION**
Training on compassionate communication for cancer care team including how to approach these conversations with the patient and their family
- 3 COLLABORATION**
A **goals of care conversation** between the cancer care team and patient and their relatives to establish a multidimensional treatment plan
- 4 REVIEW**
Periodic review and evaluation of the treatment plan using the **summary of care form** with patients and relatives, depending on patient's place of stay, care needs, and local possibilities
- 5 FINAL PHASE**
Training for clinicians on how to identify the end of life phase and where referral for palliative care might be appropriate





Where do we go from here?

A global model of public health approach to palliative care





Transitional care: discussion

- **Accessible palliative care for everyone in Europe**
 - Differences between countries
 - Differences between marginal groups
 - LGBTI
- **Palliative care and the role of digital communication**
 - Can ultimate humane care be digitalized?
- **Palliative care and compassionate communities**
 - Community care as a key, caring for each other
 - Together with specialized care when needed



Supporting people when living with serious illness

People living with serious illness need timely, appropriate support, and investing in palliative care helps manage symptoms, navigate complex needs, and ensure compassionate, responsive care throughout illness.

Palliative Care: It's about living, not just dying.

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A paradigm-shift in palliative care of cancer: lessons learned from the PAINLESS project

M^a Teresa Carrillo de la Peña

University of Santiago de Compostela, Spain



This Painless project has received funding from European Union's Horizon Europe Research and Innovation Programme under Grant Agreement N°101057367



Palliative care of cancer: a paradigm shift is needed

How is currently?

- **Late** (end-of-life care)
- Care models designed by **researchers or clinicians**
- Triggered by **cancer stage**

How it should be?

- **Early** (since diagnosis)
- **Co-designed** care model (PPI)
- Triggered by **symptoms and QoL**



Palliative care of cancer: a paradigm shift is needed

How is currently?

- **Fragmented** by symptoms, biomedical
- **Discontinuous**
- **Disease-centred**
- **Increased burden over healthcare systems**

How it should be?

- **Holistic, biopsychosocial**
- **Continuous**
- **Patient-centred**
- **No increased burden over healthcare systems**



EARLY

Physical, emotional, cognitive and social consequences after a cancer diagnosis



Impact QoL and functioning



Poor prognosis

The sooner the intervention, the better QoL and prognosis



CO-DESIGNED CARE MODEL

Early Palliative Care (EPC) should respond to **unmet needs**.

The care model should be **co-designed with patients, caregivers and a multidisciplinary team of healthcare professionals**.



TRIGGERED BY SYMPTOMS AND QoL

EPC should NOT be triggered by advanced cancer stages.

Pain and decline in QoL should trigger EPC

Why pain?

- **Most feared symptom** (suffering)
- **Large prevalence** (aprox. 44.5%); **through the cancer continuum**
- Related to **comorbid symptoms** (physical, emotional, cognitive, social)
- **Large impact on QoL and functionality**



HOLISTIC and BIOPSYCHOSOCIAL

Cancer has many aftereffects...

- **Physical symptoms** (pain, fatigue, sleep disorders)
- **Emotional problems** (anxiety, depression, distress)
- **Cognitive decline**
- **Social isolation/loneliness**

The intervention should be based on Multicomponent Management Programs delivered by interdisciplinary teams, following a biopsychosocial approach



CONTINUOUS

- **EPC should not be delivered solely at medical appointments** (spaced out over time).
- **A continuous monitoring** of the patients is needed.

Feeling well cared for by the healthcare system is essential for well-being.



PATIENT-CENTRED

- Objectives of EPC should be **adapted to each person.**
- Targets should be dynamically **adapted according to the patient's progress**

Patients should have an **active role in decision-making.**



NO INCREASED BURDEN OVER HEALTHCARE SYSTEMS

A paradigm shift IS possible without increasing the strain on the systems



Improving coordination (referral guidelines)

Reducing costs of inefficient pharmacological treatments

Improving education of healthcare professionals (biopsychsocial approach)

Using e-health tools

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Use of e-health technologies: experience in Painless



This project has received funding from European Union's Horizon Europe Research and Innovation Programme under Grant Agreement N°101057367





Painless platform for Assessment

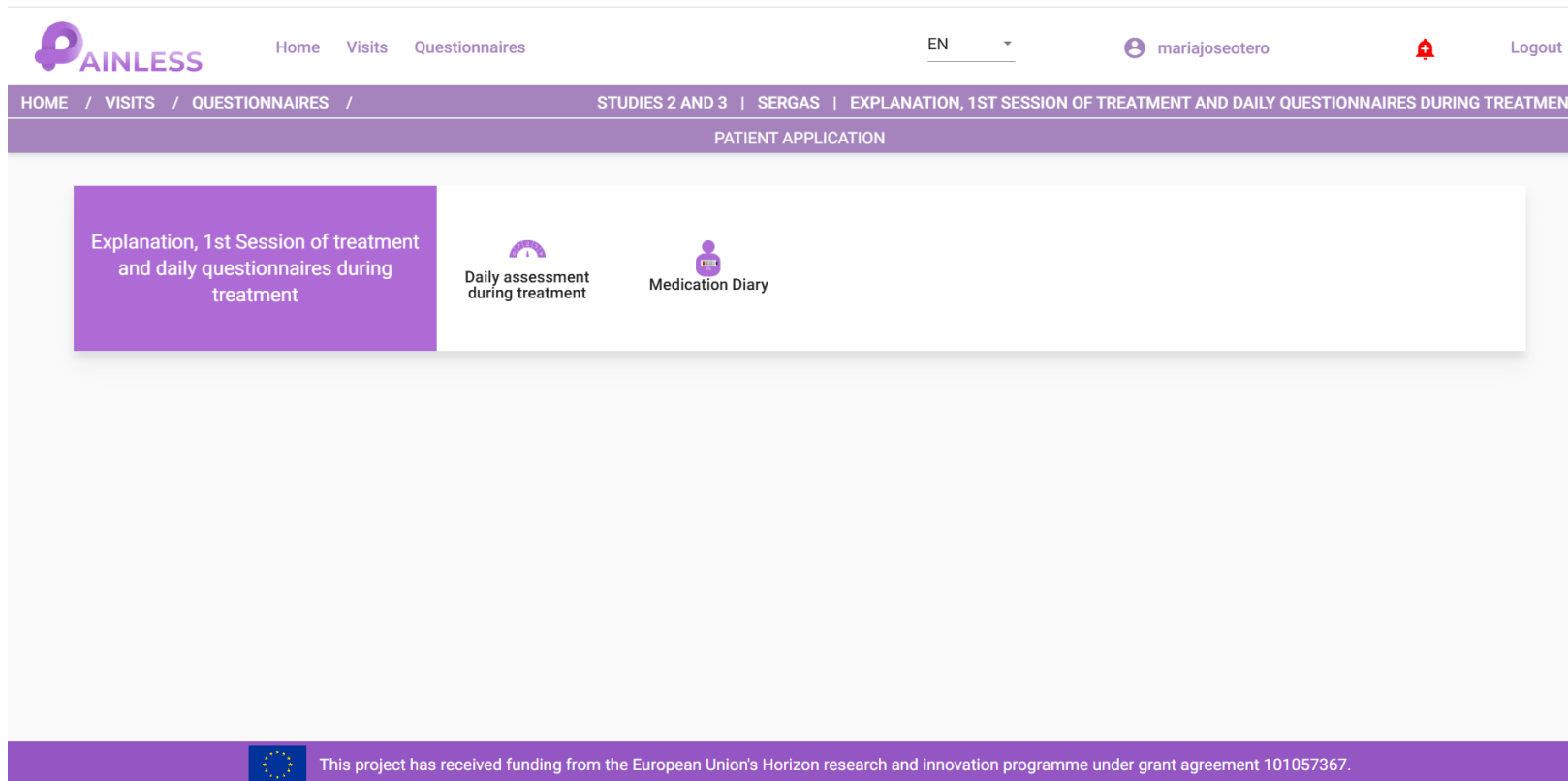
The screenshot displays the PAINLESS platform interface. At the top, there is a navigation bar with the PAINLESS logo, links for Home, Visits, and Questionnaires, a language dropdown set to EN, a user profile for antoniogonzalez, and a Logout button. Below this is a breadcrumb trail: HOME / VISITS / QUESTIONNAIRES / STUDIES 2 AND 3 | SERGAS | GENERAL ASSESSMENT AND DAILY QUESTIONNAIRES PRE-TREATMENT. The main section is titled PATIENT APPLICATION. On the left, a large purple box contains the text "General Assessment and Daily Questionnaires Pre-Treatment". To the right, a grid of 12 assessment tools is displayed, each with an icon and a title: Pain Intensity & Distress, 36-Item Short Form Survey (SF-36), EQ-5D-3L, Modified Fatigue Impact, Pain Catastrophizing Scale, Patient Health Questionnaire-9, General Anxiety Disorder-7, Sleep Scale from the Medical Outcomes Study, ONCOFOG QUESTIONNAIRE (OFQ), Daily assessment pre treatment, Medication Diary, and Socio-Economic Questionnaire. At the bottom, a footer bar features the European Union flag and the text: "This project has received funding from the European Union's Horizon research and innovation programme under grant agreement 101057367."

**Hybrid
Assessment
(face-to-face and
online)**

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Painless platform for Monitoring & follow-up

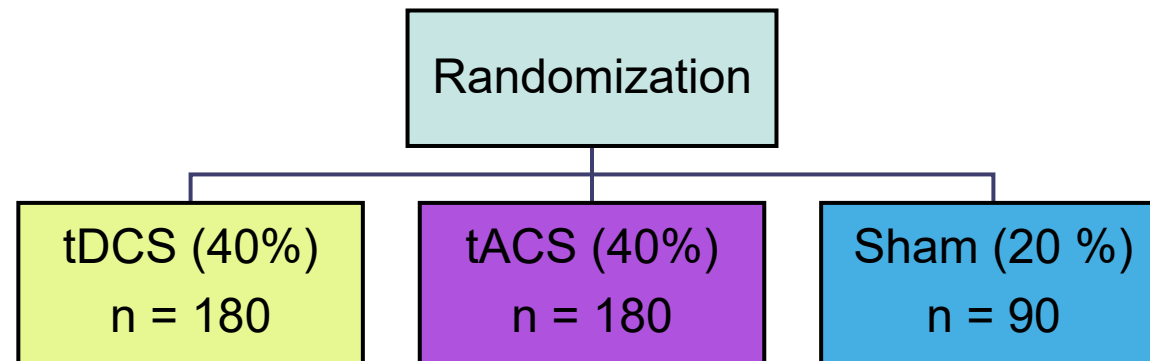


**Online monitoring of
symptoms and medication
diary**

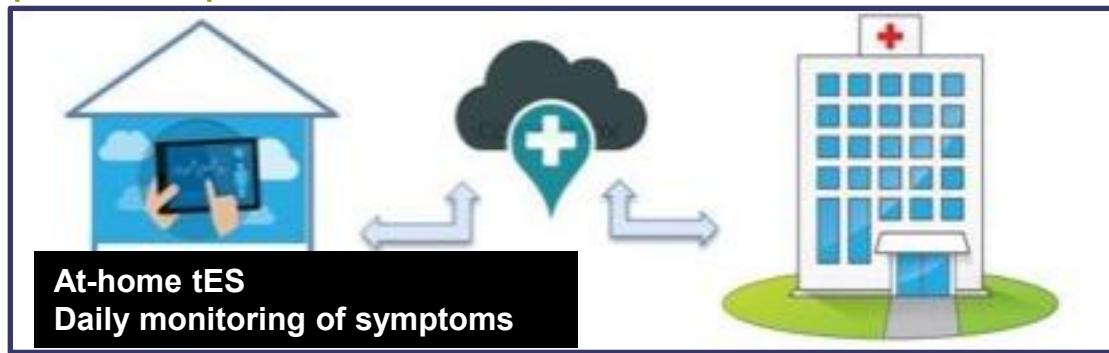
**Pre-intervention
During-intervention
Post-intervention
(45 days)**



Painless intervention at home

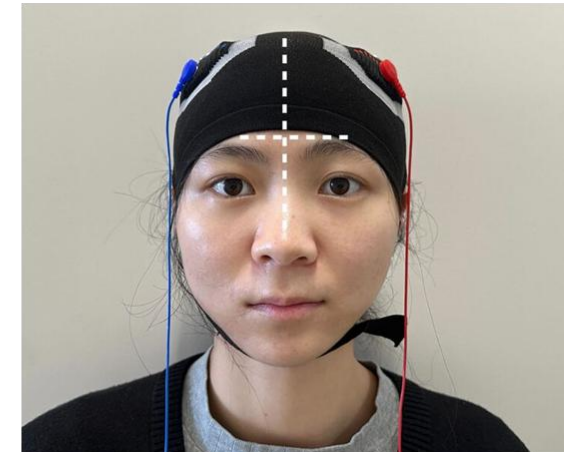
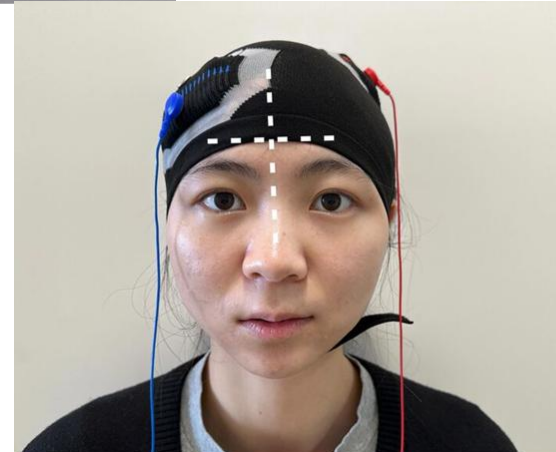


- **Randomized clinical trial, 3 arms, placebo-controlled, double-blind, multicentric study.**
- 450 patients with oncological pain in **6 clinical units**.
- Assessment: pre- and post-intervention, and 3 and 6 month follow-ups





Painless intervention at home





E-health tools for assessment of symptoms: feasibility and adherence

Barriers

- **Low digital literacy** (not adequate for **older patients**)
- **Burden** of continuous monitoring (decrease enrollment and adherence)

Facilitators

- **E-health literacy**
- **Support from carers, relatives.** If necessary, assessment in the face-to-face interview.
- Continuous **support by the team** (communication via **whatsapp** to ensure daily tests are completed; minimum 10 days in each phase)

Daily monitoring: 90.7% of the patients completed the pre- and during assessment. 64.8% also completed the post-treatment



Home-based neuromodulation

Barriers

- **Technical problems (<4%)**
- **Difficulty to manage the devices (<4%)**
- **Side effects (<6%)**
- **Burden of intervention + continuous monitoring**

Facilitators

- **Supervision from the team, regular checks of devices**
- **Explanation in the clinic. Tutorials and videotutorials.**
- **Support by the team (whatsapp)**



A hibrid intervention (face-to-face visits + home-based neuromodulation) supported by e-health tools

Is feasible

Improves patient comfort (fewer visits to the clinic)

Demonstrates high levels of adherence and acceptance

Is viewed positively (a greater sense of being well looked after)



A CHANGE OF PARADIGM NEEDS A CHANGE IN LANGUAGE

PALLIATIVE

Comes from the Latin root *pallium*. *Verbe palliare*: means "to shield". Rather than curing an illness, the word reflects the idea of **wrapping a patient in comfort and protection to ease their pain.**

With the time, patients and physicians **incorrectly associated palliative with end-of-life and hospice care**

SUPPORTIVE

A broad category of services delivered through **the cancer trajectory**. **Outpatient** symptoms management

Overarching umbrella (includes palliative care for life-threatening illnesses).

Remove the “psychological barrier” and encourage patients to seek **symptom relief earlier.**

Supportive versus palliative care: What's in a name?[†]

A survey of medical oncologists and midlevel providers at a comprehensive cancer center

Nada Fadul MD ✉, Ahmed Elsayem MD, J. Lynn Palmer PhD, Egidio Del Fabbro MD, Kay Swint MSN, BSN, Zhijun Li MS, Valerie Poulter BSN, OCN, Eduardo Bruera MD



EUROPEAN UNION



THANK YOU!
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EUniWell Champion 2026-2027. Principal investigator of Painless. Full Professor at University of Santiago de Compostela.



 **Universidade de Santiago de Compostela**



Universidad de Deusto

Parallel workshop 2 - Integrate palliative care across the whole cancer continuum: boost social innovation, enhance cross-sectoral collaboration, and ensure dying with dignity.



Dr Amanda Drury

Professor in Nursing at Trinity College Dublin and member of the EU Cancer Mission Board



Lieve Van den Block

Professor of Ageing and Palliative Care at the Vrije Universiteit Brussel (VUB) and chair of the End-of-Life Care Research Group of VUB and Ghent University



Jeroen Hasselaar

Professor of Social Empowerment in Palliative Care at Radboud University Medical Center in the Netherlands and President of the European Association for Palliative Care



María Teresa Carrillo De La Peña

Professor at the University of Santiago de Compostela in Spain

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